# Claims Clues

A Publication of the AHCCCS Claims Department April, 2002

## Medicare Cost Sharing for Plans Clarified

The AHCCCS Office of Managed Care has clarified the Medicare Cost Sharing Policy for AHCCCS acute care and ALTCS health plans.

As a result, some health plans are following the policy more closely than before, and this has caused some confusion in the provider community. The policy states:

"Contractors shall have no cost sharing obligation if the Medicare payment exceeds the Contractor's contracted rate for the services. The Contractor's liability for cost sharing plus the amount of Medicare's payment shall not exceed the Contractor's contracted rate for the service. With respect to copayments, the Contractor may pay the lesser of the copayment, or their contracted rate."

Some plans may apply the policy more liberally with the understanding that the Medicare Cost Sharing Policy presents the most restrictive methodology for reimbursement.

Several providers have noted that the AHCCCS Administration pays the full coinsurance and deductible for claims for fee-for-service recipients. This is because the AHCCCS State Plan for fee-for-service payments is different from its managed care contractors.

Questions regarding the policy may be directed to Anne Winter in the Office of Managed Care at (602) 417-4591. ❒

## Reimbursement of SESP Claims Halted

The AHCCCS Administration has suspended reimbursement of claims for services provided to State Emergency Services Program (SESP) recipients due to a lack of appropriated funds.

Legislation approved during the recently completed Third Special Session (Laws 2002, Third Special Session, Chapter 1, Section 3) eliminated reimbursement for inpatient and outpatient hospital claims for SESP recipients with dates of service on and after March 1, 2002.

In addition, no payments have been made after March 21 to any other providers for SESP claims due to a lack of appropriated funds. AHCCCS is pending the non-hospital claims for SESP recipients while awaiting a decision by the Legislature regarding additional Fiscal Year 2002 funding.

Reimbursement of claims for the treatment of end stage renal disease and for radiation and chemotherapy to treat a diagnosed cancer for persons who were determined eligible on or before November 1, 2001 is not impacted by the lack of SESP funding. ❒

## Remit Identifies Required Medical Documentation

Effective April 1, the AHCCCS Claims Medical Review Unit will no longer routinely send billing providers a "Medical Documentation Request Form" when additional medical records are required to process a claim.

The Remittance Advice that is mailed to the billing provider lists the denial reason codes, and the code definitions are printed on the Processing Notes page. Medical Review denial codes are very specific and identify which documents are being requested.

Example: MD006 = Resubmit with discharge summary.

Providers must enter the Claim Reference Number (CRN) on the documentation so that it can be linked to the appropriate claim.

If the Medical Review Unit needs to make an unusual or complex request, the "Medical Documentation Request Form" will be used as in the past. ❒

**Anesthesia Providers: Please See Attached Survey**

*Claims Clues* is published monthly as a supplement to the *AHCCCS Fee-For Service Provider Manual* and the *AHCCCS Native American Billing Manual*

# Providers Advised On Correct Use of Modifier 59

Modifier 59 (Distinct procedural service) is used to indicate that a procedure or service was distinct or independent from other services performed on the same day.

The 2002 CPT definition of Modifier 59 states:

"Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/ excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician."

According to *Medicare B News*, "when another already established modifier is appropriate, it should be used first or in combination with the Modifier 59 when necessary."

Medical documentation reflecting appropriate use of Modifier 59 must be submitted with the claim.

Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261-77499).

Example 1:

Recipient is taken to operating room for repair of fractures of the arm and leg. The provider performs both procedures during the *same session*.

**Incorrect** billing:

25515 Open treatment of radial shaft fracture, with or without internal or external fixation

27500-59 Closed treatment of femoral shaft fracture, without manipulation

**Correct** billing:

25515

27500-51

The provider must bill this way because both procedures were performed during the *same surgical session*.

Example 2:

The provider takes the patient back to the OR on the same day.

**Correct** billing:

25515

27500-51

27507-59 Open treatment of femoral shaft fracture with plate/screws

Modifier 59 is allowed because the surgery was performed during a *different surgical session* on the same date of service. The provider will be paid 100 per cent for 27507-59.

Providers should consult CCI, Version 7.3, Pages IA12-13, and *Medicare B News* and for information. ❒

# Supplemental Documents Must Identify CRN

Providers who submit supplemental documentation to the AHCCCS Administration after submitting a claim form must identify the claim to which the documentation is to be linked in the AHCCCS Claims Processing System.

Providers should indicate the appropriate Claim Reference Number (CRN) on the supplemental documentation.

If the supplemental documentation is to be linked to a claim that has been denied, providers must add an "A" in front of the CRN. This will alert AHCCCS that the claim must be reopened and the documentation routed to the correct location (e.g., Medical Review) for adjudication.

Otherwise, the documentation will be linked to the already denied claim, and it will remain denied.

These guidelines apply to claims submitted on paper and also electronically.

Questions about claim submission should be directed to the AHCCCS Claims Customer Service Unit at:

- Phoenix area: (602) 417-7670 (Select option 4)
- In state: 1-800-794-6862, Ext. 77670 (Select Option 4)
- Out of State: 1-800-523-0231) ❒

# Anesthesia Services

# Billing Survey

The AHCCCS Claims Department is examining alternative methods of processing bills for anesthesia services.

AHCCCS currently requires providers to bill the appropriate ASA code and only the number of time units, in 15-minute increments. This is because the AHCCCS system maintains base units for each ASA code. Base units are systematically added to the number of units billed, and the total is multiplied by $26.49 to obtain the allowed amount. Depending on the survey results, we would consider changing this part of the process.

Anesthesia providers are encouraged to complete this survey. Results of the survey will help AHCCCS determine if the current policies and procedures regarding billing for anesthesia services should be modified.

Please return mail or fax survey to:

AHCCCS Claims Policy Section
Mail Drop 8100
701 E. Jefferson Street
Phoenix, AZ 85034

AHCCCS Claims Policy Section
Fax: (602) 256-1474

1. Do any other third party payers follow AHCCCS billing requirements? ☐ Yes ☐ No (Go to No. 3)

2. If you checked "Yes" above, how many payers follow AHCCCS billing requirements? _____

3. Describe the most common billing requirements of other third party payers (e.g., time, base plus time, etc.).

_____

_____

_____

4. Do you prefer the billing requirements described in No. 3? ☐ Yes ☐ No (Describe your preferred billing method below)

_____

_____

_____

Provider Name: _____

Name of contact person: _____ Provider ID: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Telephone: ( ) _____ E-mail: _____